SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Filing at a Glance

Company: MedAmerica Insurance Company

Product Name: S2-345R-AR	SERFF Tr Num: MEAM-126128663	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 42219
Sub-TOI: LTC03I.004 Partnership	Co Tr Num: S2-345R-AR	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Marie Bennett
	Author: Lisa Culhane	Disposition Date: 06/24/2009
	Date Submitted: 04/27/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: S2-345R-AR	Status of Filing in Domicile:
Project Number: S2-345R-AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/24/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/24/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

The enclosed form filing is submitted for your review and approval. This Long Term Care Insurance Product is intended to be tax-qualified under section 7702B(b) of the Internal Revenue Code. Revisions have been made to our applications deleting our Affiliation program and replacing it with Association. Also simplify our application process by creating a Simplified and Modified application. The Policy and forms were originally approved under SPL2-336-AR-0708 on 8/13/2008.

Please see cover letter for details.

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Company and Contact

Filing Contact Information

Lisa Culhane, LTC Compliance Analyst
165 Court Street
Rochester , NY 14647

lisa.culhane@medamericaltc.com
(585) 327-6550 [Phone]
(585) 238-3642[FAX]

Filing Company Information

MedAmerica Insurance Company
165 Court Street

Rochester, NY 14647
(585) 327-6522 ext. [Phone]

CoCode: 69515
Group Code:

Group Name:
FEIN Number: 34-0977231

State of Domicile: Pennsylvania
Company Type: Long Term Care Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 per filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MedAmerica Insurance Company	$50.00	04/27/2009	27436271

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Marie Bennett	06/24/2009	06/24/2009

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
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TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Disposition

Disposition Date: 06/24/2009
Implementation Date:
Status: Approved-Closed
Comment: APPROVAL IS SUBJECT TO COMPLIANCE WITH ACA 23-97-203 REQUIRING DEPARTMENT APPROVAL OF AN ASSOCIATION PRIOR TO MARKETING TO SAID ASSOCIATION.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter		Yes
Form	Application – Individual		Yes
Form	Application – EP / Association A		Yes
Form	Application – EP / Association B		Yes

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Form Schedule

Lead Form Number: S2-345R-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	S2-345R-AR	Application/ Enrollment	Application – Individual Form	Revised	Replaced Form #: S2-345-AR-0708 Previous Filing #:	0	S2-345R-AR.pdf
	S2-346A-AR	Application/ Enrollment	Application – EP / Association A Form	Initial		0	S2-346A-AR.pdf
	S2-346B-AR	Application/ Enrollment	Application – EP / Association B Form	Initial		0	S2-346B-AR.pdf

MEDAmerica INSURANCE COMPANY
An Excellus Company — Home Office: Pittsburgh, PA

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity^{ii}

Long Term Care Insurance
TAX QUALIFIED COVERAGE

STANDARD APPLICATION
SPL2-336-AR-0708

❒ NEW POLICY
❒ COVERAGE INCREASE
Indicate your current policy number here: _____

I. APPLICANT INFORMATION: 5 Questions to Complete

1. IDENTIFYING INFORMATION

Applicant Name (First, MI, Last)			Social Security Number
Legal Residence Street Address (PO Box Not Adequate-Must Provide Street)			Mailing/Delivery Street Address (if different)
City State Zip			City State Zip
( ) Home Phone	( ) Work Phone	☐ AM ☐ PM Best Time to Call	Email
____/____/____ MM / DD / YYYY Date of Birth	Age (On Date Signed)	☐ Male ☐ Female Sex	Ft. In. Ht. (Check BMI Table) / Lbs. Wt

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Single with Care Partner* ☐ Widowed with Care Partner*

** If you are Widowed or Single and applying for the Care Partner Premium, the Care Partner Statement must be signed.*

2. CARE PARTNER (Spouse/Domestic Partner) INFORMATION

a) Is your Care Partner (Spouse/Domestic Partner) applying for coverage at this time? ☐ YES* ☐ NO If YES, answer (c)

b) Does your Care Partner (Spouse /Domestic Partner) have a MedAmerica policy? ☐ YES* ☐ NO If YES, answer (c)

c) Care Partner (Spouse /Domestic Partner) name and SS# : _____ (Name (First, MI, Last)) __ __ __ - __ __ - __ __ __ __ (Social Security Number)

** Single or Widowed Care Partners must complete the Care Partner Statement.*

3. ALTERNATE EFFECTIVE DATE

☐ Same as Care Partner (Spouse/Domestic Partner) ☐ Other: _____ Refer to Conditional Receipt.

4. ALTERNATE BILLING ADDRESS: Address that applicant is requesting billing be mailed to IF different than the Applicant Address.

Name (First, MI, Last)			( ) Phone Number
Street Address	City	State	Zip

5. BENEFICIARY (optional) A Beneficiary is a person(s) named by You to receive any premiums that may be due in the event of Your death.

Beneficiary Name (First, MI, Last)	Relationship	( ) Phone Number
Street Address	City	State Zip

OFFICE USE ONLY App. Rec: _____ App Status: _____ UW Date: _____ Init: _____

☐ Preferred ☐ Standard Effective Date: _____

II. POLICY BENEFIT SELECTION: 7 Steps to Complete

STEP 1: SELECT TYPE OF COVERAGE: A. , B. , OR C.

A. ☐ COMPREHENSIVE COVERAGE

STEP 2: CASH BENEFIT ACCOUNT (Choose One)	STEP 3: MONTHLY CASH BENEFIT (Choose One from Same Row as Cash Benefit Account)			
	MONTHLY CASH BENEFIT	EFB: [1] Increase Facility Benefit to:	MONTHLY CASH BENEFIT	EFB: [1] Increase Facility Benefit to:
☐ $100,000 2 Options: a or b	a. ☐ $1,500	☐ EFB $2,000		
	b. ☐ $3,000 [2]	☐ EFB $4,000		
☐ $200,000 4 Options: a, b, c, or d	a. ☐ $1,500	☐ EFB $2,000	c. ☐ $4,500	☐ EFB $6,000
	b. ☐ $3,000	☐ EFB $4,000	d. ☐ $6,000 [2]	☐ EFB $8,000
☐ $300,000 4 Options: a, b, c, or d	a. ☐ $3,000	☐ EFB $4,000	c. ☐ $6,000	☐ EFB $8,000
	b. ☐ $4,500	☐ EFB $6,000	d. ☐ $7,500	☐ EFB $10,000 [2]
☐ $500,000 4 Options: a, b, c, or d	a. ☐ $4,500	☐ EFB $6,000	c. ☐ $7,500	☐ EFB $10,000
	b. ☐ $6,000	☐ EFB $8,000	d. ☐ $9,000	☐ EFB $12,000
☐ $1,000,000 4 Options: a, b, c, or d	a. ☐ $6,000	☐ EFB $8,000	c. ☐ $9,000	☐ EFB $12,000
	b. ☐ $7,500	☐ EFB $10,000	d. ☐ $12,000	☐ EFB $16,000

[1] EFB- ENHANCED FACILITY BENEFIT (Optional): If Selected Increases Facility Coverage to EFB Amount Indicated

[2] Shared Care Rider is Not Available with these Combinations

B. ☐ COMMUNITY ONLY (Initials Required Below) Shared Care Rider is Not Available

STEP 2: CASH BENEFIT ACCOUNT (Choose a, b, or c)	STEP 3: MONTHLY CASH BENEFIT Choose One From Same Row as Cash Benefit Account
a. ☐ $100,000	a. ☐ $1,500 b. ☐ $3,000
b. ☐ $200,000 c. ☐ $300,000	a. ☐ $3,000 b. ☐ $4,500 c. ☐ $6,000

Initials Required: I have elected to purchase the Community Only Rider. I understand that by choosing this Rider, I am limiting my coverage to care provided when I do not reside in a Qualified Facility. I may not have coverage for all the types of long term care services I might require. *Initial Here* ☛

C. ☐ FACILITY ONLY (Initials Required Below) Shared Care Rider is Not Available

STEP 2: CASH BENEFIT ACCOUNT (Choose a, b, c, or d)	STEP 3: MONTHLY CASH BENEFIT Choose One From Same Row as Cash Benefit Account
a. ☐ $200,000 b. ☐ $300,000	a. ☐ $3,000 b. ☐ $4,500 c. ☐ $6,000
c. ☐ $500,000 d. ☐ $1,000,000	a. ☐ $6,000 b. ☐ $7,500 c. ☐ $9,000

Initials Required: I have elected to purchase the Facility Only Rider. I understand that by choosing this Rider, I am limiting my coverage to care provided when I reside in a Qualified Facility. I may not have coverage for all the types of long term care services I might require. *Initial Here* ☛

STEP 4: ELIMINATION PERIOD Choose One	STEP 5: INFLATION Choose One	STEP 6: PREMIUM PAYMENT OPTIONS Choose One
☐ 30 Days	☐ 5% Simple ☐ None	☐ Lifetime
☐ 60 Days	☐ 3% Compound: No Max	☐ 10 Pay
☐ 90 Days	☐ 5% Compound: No Max	☐ Paid Up at Age 65 [3]
☐ 180 Days	☐ 5% Compound 2x Max	[3] Not available after age 55

II. POLICY BENEFIT SELECTION (Continued)

STEP 7: RIDERS: Riders are available only at the time of Original Purchase Unless otherwise stated.		Check Riders You Are Applying For
Shared Care Rider [4]	*Policies must be identical in benefits and premium payment options.* *Also **not** available with:* • *Restoration of Benefits Rider;* • *Comprehensive Coverage $100,000 Cash Benefit Account and $3,000 Monthly Cash Benefit;* • *Comprehensive Coverage $200,000 Cash Benefit Account and $6,000 Monthly Cash Benefit;* • *Comprehensive Coverage $300,000 Cash Benefit Account and $10,000 Enhanced Facility Benefit*	☐
Shared Waiver Rider [4]	• *Not available if Care Partners' age difference is more than 15 years.*	☐
Survivor Benefit Rider [4]	• *Not available if Care Partners' age difference is more than 15 years* • *Not available with 10 Pay Premium Payment Option.*	☐
[4] *For all of the above Shared Riders:* • *Not available with Community Only or Facility Only* • *Both Care Partners Must Purchase the Riders and the Riders must have the Same Effective Date.* • *If one Care Partner is Not Eligible or Does Not Apply, they must apply within 6 months of the Original Care Partner and the Original Care Partner can not be Eligible for Benefits at the time the Rider is requested.*		
[Restoration of Benefits Rider	• *Not Available with Community Only* • *Not available with Shared Care Rider.*	☐]
Non-forfeiture Riders	[Return of Premium Rider: *Available to Applicants Age 75 and Under. Not available with Community Only Rider OR Full Return of Premium Rider*	☐]
	[Full Return of Premium Rider: *Available to Applicants Age 65 and Under. Not available with Community Only Rider OR Return of Premium Rider*	☐]
	Shortened Benefit Period Rider	☐

III. INSURANCE HISTORY

1. Are you covered by a state assistance program (Medicaid)?
If YES, as a Medicaid recipient you probably should not apply for this coverage. We recommend ending the application at this point. ☐ YES ☐ NO

2. Do you currently or have you had in the last 12 months another nursing home (NH), home health care, long term care insurance policy, rider or certificate in force? If Lapsed, Provide Term Date ☐ YES ☐ NO
If YES, please provide the following information. (Please use extra paper if needed)

2a). Company Name	Address (Street, City, State, Zip)			Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only	
Still In Force ☐ Yes ☐ No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

2b). Company Name	Address (Street, City, State, Zip)			Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only	
Still In Force ☐ Yes ☐ No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

3. Are you allowing any other nursing home (NH), home health care, long term care insurance policy, rider or certificate to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate with this policy? If Lapsed, Provide Term Date ☐ YES ☐ NO
If YES, You must sign both Notices Regarding Replacement of Accident and Sickness or Long term Care Insurance Forms. Submit Company Copy with this Application and retain the Applicant Copy.

Company Name	Address (Street, City, State, Zip)			Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only	
Still In Force ☐ Yes ☐ No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

IV. PREMIUM PAYMENT INFORMATION: All Applicants must CHOOSE ONE method and complete required information.

1. ☐ DIRECT BILL

Select the frequency of your Direct Billing payment

☐ Quarterly

☐ Semi-Annual

☐ Annual

2. ☐ ELECTRONIC FUNDS TRANSFER (EFT)

Select the frequency of your EFT payment.

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

_____
Bank Name

_____ _____
Bank Account Number Routing Number (9 numbers)

Requires Minimum of 2 months Conditional Premium. Attach Voided Check if Requesting EFT from Different Bank Account than Conditional Premium Check.

*Sign Authorization Below

3. ☐ CREDIT CARD

Select the frequency of your Credit Card payment

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ VISA ☐ MASTERCARD

_____
Credit Card Number

_____
Expiration Date MM/YY

*Sign Authorization Below

*Authorization for EFT and Credit Card: Required IF Choosing EFT OR Credit Card Payment Method

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.

☛_____
Account Holder Signature

☛_____
Joint Account Holder Signature

V. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS

INSTRUCTIONS: You must answer each question by checking YES or NO.

1. Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions: ☐ YES ☐ NO

- Alzheimer's Disease, Lewy Body Disease, Dementia, Any Memory Problems, Psychosis, Schizophrenia, Mental Retardation
- Amytrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease/Parkinsonism
- Post-Polio Syndrome, Demyelinating Disease, Other Neurological Conditions affecting the brain or spinal cord
- Lupus (SLE), Mixed Connective Tissue Disease, Scleroderma, Muscular Dystrophy, Other Muscular Conditions Causing Limits
- Kidney Disease, Polycystic Kidney Disease, Liver Cirrhosis, Hepatitis, Hemachromatosis
- Amputation-Due to Disease, Double Heart Valve Replacement , Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant, Multiple Myeloma
- Peripheral Vascular Disease and Smoking, Peripheral Vascular Disease and Diabetes, Skin Ulcers and Diabetes
- 2 or more Strokes or Transient Ischemic Attacks(TIAs), Single Stroke OR TIA and Diabetes
- AIDS- *You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS*.

2. In the *past year* have you needed assistance or supervision in taking medication, performing activities of daily living*, used any Medical Equipment**, or received nursing home care, home health care, assisted living care, or adult day care services? ☐ YES ☐ NO

*Activities of Daily Living Include Bathing, Walking, Dressing, Eating, Toileting, Getting In and Out of Bed, Bowel and Bladder Control

**Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stair lift, or Home Intravenous Medications.

STOP! If questions 1 OR 2 are checked "Yes," we cannot offer coverage at this time. Do not Submit the Application.

3. In the *past 2 years* have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any of the following? ☐ YES ☐ NO

- Arthritis with Multiple Joint Replacements or Causing Limitations
- Cancer
- Cardiomyopathy or Congestive Heart Failure
- Chronic Blood Disorders
- Chronic Muscular or Neurological Conditions
- Vascular Disease or other Circulatory Disease
- Diabetes
- Drug/Substance Abuse
- Bowel or Bladder Problems
- Falls, Fractures, or Compression Fractures
- Joint Deformities
- Lung Disorders such as COPD or Emphysema
- Manic–Depression
- Stroke OR TIA OR Amaurosis Fugax- Single Episode

4. In the *past year* have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation? ☐ YES ☐ NO

List ALL Current Medications –Use Extra Paper if Needed. ☐ No Medications

Medication	Dosage (x/day)	Reason Taking	#Months On Med

PHYSICIANS: List ALL Physicians seen in the last 5 Years.

Physician(s) Name	Physician(s) Street Address, City, State, Zip	**Phone #**	Date Last Seen
1. Primary Care Physician			
2. Other Physicians (Indicate Specialty)			

V. INSURABILITY PROFILE (Continued) If any question in this section is answered Yes, give full details below.

Producers: Call the Underwriting Hotline for Pre-qualification Review: 1-877-233-5435

During the past 5 Years have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any condition(s) or symptom(s) of the following (1-8)?

1. Any Heart, Circulatory, Vascular, or Blood problems? ☐YES ☐ NO
   Examples (List not all inclusive): Aneurysms, Strokes, TIA, Heart Attack, Angina, Dizziness, Pacemaker, Chest Pain, Irregular Heartbeat, Vascular Headaches, Peripheral Vascular Disease, Carotid Disease, Thrombocytopenia, Anemia and Hypertension
2. Any Bone, Joint, Muscular or Connective Tissue problems? ☐YES ☐ NO
   Examples (List not all inclusive): Arthritis, Osteoporosis, Osteopenia, Back Problems, Paget's Disease, Polymyalgia, Rotator Cuff Tear, Bunion Surgery, Spinal Stenosis, Connective Tissue Disease
3. Any Respiratory Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema, Bronchitis, Sarcoidosis
4. Any Endocrine Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Diabetes, Thyroid problem, Hormone Replacement, Pancreatitis, Hyperparathyroidism
5. Any Neurological, Eye or Ear Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Bell's Palsy, Blindness, Carpal Tunnel, Cerebral Palsy, Epilepsy, Parkinson's Restless Leg, Seizure Disorder, Tremors, Unsteadiness, Loss of Balance, Falls, Glaucoma, Macular Degeneration
6. Any Mental, Alcohol or Drug Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Anxiety, Depression, Alcoholism, Manic Depression, Memory Loss
7. Any Digestive, Bladder, or Kidney Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Colitis, Colon Polyps, Gallbladder Disease, GI Bleed, Hiatal Hernia, Loss of Appetite, Nephrectomy, Renal Disease, Prostate Enlargement, Stress Incontinence, Weight Gain, Weight Loss, Dyspepsia
8. Any Cancer? ☐YES ☐ NO
   Examples (List not all inclusive): Breast Cancer, Prostate Cancer, Uterine Cancer, Thyroid Cancer, Leukemia, Skin Cancer
9. Have you *ever* been turned down for nursing home, home health care, or disability insurance? If "Yes:" ☐YES ☐ NO
   Company/Reason: Date:
10. In the *past 2* years have you used tobacco products? ☐YES ☐ NO
    If "YES," Type: _____Amount/Frequency: _____/_____ *If quit, give date:* _____

Provide Details of Diagnoses including Date of Onset, Tests/Treatments/Follow-up over the last 5 Years for All Conditions.
Please use extra sheet of paper if needed.

Description of Condition/Problem	Date of Onset MM/YYYY	Type of Tests/Treatment/Follow-Up/Medication Changes in last 5 years	# Months Stable (No Change in Treatment)

VI. HIPAA MEDICAL AUTHORIZATION (Uses and Disclosures of Medical Information)
Must be signed by all applicants.

This is a HIPAA compliant authorization. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of medical information about me.

From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic or other health care provider or health related facility, including but not limited to those listed above, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments, to furnish MedAmerica Insurance Company and/or designated business associates acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the [LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com]. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

PRINT APPLICANT NAME: _____

APPLICANT DATE OF BIRTH: _____

APPLICANT SOCIAL SECURITY NUMBER: _____

☛ APPLICANT'S SIGNATURE: _____ DATE: _____

VII. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

2. PROTECTION AGAINST UNINTENDED LAPSE: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 31 days after a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, I select *one* of the following options:

   ☐ I elect NOT to designate any person to receive such notice.

   ☐ I designate the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

Name:_____ Phone Number:_____

Address:_____
Street City State Zip

3. INFLATION PROTECTION OPTION: I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this Policy with and without inflation protection, and

   ☐ I ACCEPT inflation protection.
   ☐ I REJECT inflation protection.

4. SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER: I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

   ☐ I ACCEPT the Shortened Benefit Period Non-forfeiture Rider.
   ☐ I REJECT the Shortened Benefit Period Non-forfeiture Rider.

5. DECLARATION AND APPLICATION CONDITIONS

   To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use this application or require, at their expense, that I see a health care professional to determine if my application is accepted. I understand that the premium for the coverage I have applied for is based on medical underwriting. The premium I was quoted includes certain assumptions regarding my health. Therefore, the premium for my policy may be different from the premium I was quoted. My coverage will begin when I am notified of the effective date of coverage, or if selected, my alternate effective date. To receive benefits under this policy, I understand I must satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

   I acknowledge receipt of the Outline of Coverage, Suitability Personal Worksheet (if applicable in my state), Rate and Disclosure Form (if applicable in my state), and appropriate Shopper's Guide.

   I understand the Producer or Broker of Record for my Policy, and any managing entities (which may include an affiliate of the Company), may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

I understand that with this signature I am agreeing with all applicable conditions contained in this Section.

Dated at: City_____State_____Month _____ Day_____Year_____

☛ APPLICANT SIGNATURE: _____

VIII. PRODUCER STATEMENT

1. Has the Applicant purchased any other health insurance policy from you during the past five (5) years? *If Yes, provide the following information:*

COMPANY	TYPE OF POLICY	POLICY NUMBER	IN FORCE:
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO

2. By my signature on this form I certify that:
   (a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
   (b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
   (c) I am in compliance with the Long Term Care Insurance requirements in the state of residence of the Applicant as shown on his/her/their Application.
   (d) I have delivered the Outline of Coverage, Suitability Personal Worksheet (where required), and Rate Disclosure Form (where required), and appropriate Shopper's Guide to the Applicant at the first time of solicitation.

_____ _____
Soliciting Producer Name (*Please print)* Writing Number

_____
Agency Name

Phone Number (Best number to reach soliciting producer) : (_____) - _____

SOLICITING PRODUCER SIGNATURE:_____ DATE: _____

3. Are you SPLITTING the Commission Payment? ☐ YES ☐ NO

If YES, List all producers receiving compensation, their Writing Number(s), and % splits. The first producer listed MUST be the soliciting producer and the producer of record. Case splits must total 100%. (*Only Licensed and Appointed Producers/Brokers may receive compensation.)*

Soliciting Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
Co-Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
Co-Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
Co-Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
Co-Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
Co-Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
Co-Producer Name:	_____ Please Print First Name, Last Name	Writing#:_____	_____ %
		TOTAL:	100 %

4. How was case quoted? ☐ Preferred ☐ Standard (You are required to Attach a Proposal Quote)

Amount of Conditional Premium Check (attached): $_____
As per the Conditional Receipt, Modal Premium is Required*
*If EFT, 2 months premium is required

Special Requests, Remarks, and Instructions:

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity II℠
Long Term Care Insurance
TAX QUALIFIED COVERAGE

[EMPLOYER][ASSOCIATION]
PROGRAM APPLICATION
SPL2-336-AR-0708

EP Name: _____

Case Number: _____

I. APPLICANT INFORMATION:

1. IDENTIFYING INFORMATION

Applicant Name (First, MI, Last)	Social Security Number

Legal Residence Street Address (no PO Box - Must Provide Street Address)	Delivery Street Address (if different)
Note: If you receive your mail at a PO Box: that address MUST be recorded in Alternate Billing Address	
City State Zip	City State Zip

Home Phone ( )	Work Phone ( )	Email:

Date of Birth: ___/___/___ MM / DD / YYYY	Age (On Date Signed)	Sex: ☐ Male ☐ Female	Census ID: (If Applicable)

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Single with Care Partner* ☐ Widowed with Care Partner*

* *The Care Partner Statement must be signed by both Care Partners even if only one Care Partner is applying for coverage.*

2. EMPLOYMENT/ELIGIBILITY STATUS FOR [EMPLOYER][ASSOCIATION] PROGRAM: CHECK ONLY ONE ELIGIBILITY

A. I am the Eligible of the [Employer][Association] Program (Check One)
☐ [Employee] [Active Member] ☐ [New Hire Date of Hire:] _____
[☐ Retiree] [☐ Board Member]

B. I am related to the Eligible of the [Employer][Association] Program (Check One)
[☐ Care Partner (Spouse /Domestic Partner)] [☐Parent] [☐Child (adopted & step)] [☐Parent-in-law]
[☐Care Partner of a Child] [☐ Brother/Sister (adopted, step, & in-law)] [☐Grandparent] [☐ Grandparent-in-law]

_____ _____
First, Last Name of Eligible of the[Employer][Association] Program [Eligible Census ID -SSN, Employee ID or DOB]

3. CURRENT EMPLOYMENT STATUS: CHECK A OR B

A. ☐ I MEET THE DEFINITION OF ACTIVELY-AT-WORK[1] _____
☐Employer Name and Phone# (if not the employer offering a program).
☐Self–Employed

I authorize my Employer to verify my employment status for MedAmerica Insurance Company (the Company) by phone or by census. If I am self-employed, I understand that a representative of the Company will contact me to confirm my Actively at Work status.

B. ☐ I DO NOT MEET THE DEFINITION OF ACTIVELY-AT-WORK[1]

[1]Actively At Work is a person [aged 18 to 65,] currently employed outside the home or self-employed outside the home, and not on Leave Without Pay or an authorized absence due to illness or injury for more than 5 consecutive days over the last 180 days. The Actively At Work must be regularly scheduled to work not less than 30 hours per week and be present at their Employer's place of business or an alternate work site as designated by the Employer and be performing the material and substantial duties of their jobs. If the employee works from home, they are considered Actively At Work if they are not hospital confined and not disabled to a degree that they could not have reported for work at the Employer's usual place of business and performed all the material and substantial duties of their occupations not less than 30 hours per week.

OFFICE USE ONLY: App. Rec: App Status: Eff. Date: UW Date: Init:

I. APPLICANT INFORMATION (Continued)

4. CARE PARTNER (Spouse/Domestic Partner) INFORMATION

a) Is your Care Partner (Spouse/Domestic Partner) applying for coverage at this time? ☐ YES* ☐ NO If YES, answer (c)

b) Does your Care Partner (Spouse /Domestic Partner) have a MedAmerica policy? ☐ YES* ☐ NO If YES, answer (c)

c) Care Partner (Spouse /Domestic Partner) name and SS# : _____ _____

Name (First, MI, Last) Social Security Number

* *Single or Widowed Care Partners must complete the Care Partner Statement.*

5. ALTERNATE EFFECTIVE DATE

☐ Same as Care Partner (Spouse/Domestic Partner) ☐ Other: _____ | Refer to Conditional Receipt

6. ALTERNATE BILLING ADDRESS: Address that applicant is requesting billing be mailed to IF different than the Applicant Address.

Name (First, MI, Last)			Phone Number ( )
Street Address	City	State	Zip

7. BENEFICIARY (optional) A Beneficiary is a person(s) named by You to receive any premiums that may be due in the event of Your death.

Beneficiary Name (First, MI, Last)	Relationship	Phone Number ( )
Street Address	City	State Zip

II. INSURANCE HISTORY

1. Are you covered by a state assistance program (Medicaid)?
   If YES, as a Medicaid recipient you probably should not apply for this coverage. We recommend ending the application at this point. ☐ YES ☐ NO

2. Do you currently or have you had in the last 12 months another nursing home (NH), home health care, long term care insurance policy, rider or certificate in force? If Lapsed, Provide Term Date ☐ YES ☐ NO
   If YES, please provide the following information. (Please use extra paper if needed)

2a). Company Name	Address (Street, City, State, Zip)	Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only			
Still In Force ☐ Yes ☐ No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

2b). Company Name	Address (Street, City, State, Zip)	Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only			
Still In Force ☐ Yes ☐ No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

3. Are you allowing any other nursing home (NH), home health care, long term care insurance policy, rider or certificate to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate with this policy? If Lapsed, Provide Term Date ☐ YES ☐ NO
   If YES, You must sign both Notices Regarding Replacement of Accident and Sickness or Long term Care Insurance Forms. Submit Company Copy with this Application and retain the Applicant Copy.

Company Name	Address (Street, City, State, Zip)	Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only			
Still In Force ☐ Yes ☐ No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

III. POLICY BENEFIT SELECTION: COMPREHENSIVE COVERAGE 6 Steps to Complete

STEP 1: CASH BENEFIT ACCOUNT (Choose One)	STEP 2: MONTHLY CASH BENEFIT (Choose One From the SAME Row as Your Cash Benefit Account)			
	MONTHLY CASH BENEFIT	EFB: [2] Increase Facility Benefit to:	MONTHLY CASH BENEFIT	EFB: [2] Increase Facility Benefit to:
☐ $100,000 2 Options: a or b	a. ☐ $1,500	☐EFB $2,000		
	b. ☐ $3,000 [3]	☐EFB $4,000		
☐ $200,000 4 Options: a, b, c or d	a. ☐ $1,500	☐ EFB $2,000	c. ☐ $4,500	☐EFB $6,000
	b. ☐ $3,000	☐EFB $4,000	d. ☐ $6,000 [3]	☐EFB $8,000
☐ $300,000 4 Options: a, b, c or d	a. ☐ $3,000	☐ EFB $4,000	c. ☐ $6,000	☐ EFB $8,000
	b. ☐ $4,500	☐ EFB $6,000	d. ☐ $7,500	Not Applicable
☐ $500,000 3 Options: a, b or c	a. ☐ $4,500	☐ EFB $6,000	c. ☐ $9,000	Not Applicable
	b. ☐ $6,000	☐ EFB $8,000		

[2] EFB- ENHANCED FACILITY BENEFIT (Optional): If Selected Increases Facility Coverage to EFB Amount Indicated

[3] Shared Care Rider is Not Available with these Combinations

STEP 3: ELIMINATION PERIOD Choose One	STEP 4: INFLATION Choose One	STEP 5: PREMIUM PAYMENT OPTIONS Choose One
☐ 30 Days	☐ None	☐ Lifetime
☐ 60 Days	☐ 5% Simple	☐ 10 Pay
☐ 90 Days	☐ 3% Compound: No Max	☐ Paid Up at Age 65 [4]
☐180 Days	☐ 5% Compound: No Max	
	☐ 5% Compound 2x Max	[4] Not available after age 55

STEP 6: Riders: Riders are available only at the time of Original Purchase unless otherwise stated.		Check Riders You Are Applying For
Shared Care Rider [5]	*Policies must be identical in benefits and premium payment options.* *Also **not** available with:* • *Restoration of Benefits Rider;* • *Comprehensive Coverage $100,000 Cash Benefit Account and $3,000 Monthly Cash Benefit;* • *Comprehensive Coverage $200,000 Cash Benefit Account and $6,000 Monthly Cash Benefit;*	☐
Shared Waiver Rider [5]	• *Not available if Care Partners' age difference is more than 15 years.*	☐
Survivor Benefit Rider [5]	• *Not available if Care Partners' age difference is more than 15 years.* • *Not available with 10 Pay Premium Payment Option.*	☐
[5] *For all of the above Shared Riders:* • *Both Care Partners Must Purchase the Riders and the Riders must have the Same Effective Date.* • *If one Care Partner is Not Eligible or Does Not Apply, they must apply within 6 months of the Original Care Partner and the Original Care Partner can not be Eligible for Benefits at the time the Rider is requested.*		
[Restoration of Benefits Rider.	• *Not Available with Shared Care Rider*.	☐]
Non-forfeiture Riders	[Return of Premium Rider: *Available to Applicants Age 75 and Under.* • *Not available with Full Return of Premium Rider*	☐]
	[Full Return of Premium Rider: *Available to Applicants Age 65 and Under.* • *Not available with Return of Premium Rider*	☐]
	Shortened Benefit Period Rider	☐

IV. PREMIUM PAYMENT INFORMATION: All Applicants must SELECT ONE method and complete required information.

1. ☐ DIRECT BILL

Select the frequency of your Direct Billing payment

☐ Quarterly

☐ Semi-Annual

☐ Annual

2. ☐ ELECTRONIC FUNDS TRANSFER (EFT)

Select the frequency of your EFT payment.

☐Monthly ☐Quarterly ☐Semi-Annual ☐ Annual

_____
Bank Name

_____ _____
Bank Account Number Routing Number (9 numbers)

Requires Minimum of 2 months Conditional Premium. Attach Voided Check if Requesting EFT from Different Bank Account than Conditional Premium Check.

*Sign Authorization Below

3. ☐ CREDIT CARD

Select the frequency of your Credit Card payment

☐Monthly ☐Quarterly ☐Semi-Annual ☐ Annual

☐ VISA ☐ MASTERCARD

_____
Credit Card Number

_____
Expiration Date MM/YY

*Sign Authorization Below

*Authorization for EFT and Credit Card: Required IF Choosing EFT OR Credit Card Payment Method

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.

☛_____
Account Holder Signature

☛_____
Joint Account Holder Signature

4. ☐ 100% [Employer][Association] Paid

CHECK THIS BOX ONLY IF: the [Employer][Association] is Paying THE ENTIRE Premium for the Benefits Chosen at the time of Enrollment.

If the [Employer][Association] is Paying ONLY a PORTION of the PREMIUM-DO NOT CHECK THIS BOX.

5. ☐ PAYROLL DEDUCTION (Available only if approved by [Employer][Association])

I authorize the party responsible for my payroll to deduct the applicable premium from my salary for this insurance coverage. I may revoke this authorization at any time by written notice to my [Employer][Association] OR to MedAmerica Insurance Company.

_____
Print Name of [Employee][Association Member] (First, Last Name)

☛_____]
[Employee][Association Member] Signature

[_____]
[Eligible Census ID -SSN, Employee ID or DOB]
Required if [Employee][Association Member] is NOT the Applicant

V. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

2. PROTECTION AGAINST UNINTENDED LAPSE: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 31 days after a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee.

   Therefore, I select *one* of the following options:

   ☐ I elect NOT to designate any person to receive such notice.

   ☐ I designate the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

First Name, Last Name	( ) Phone Number		
Street Address	City	State	Zip

3. INFLATION PROTECTION OPTION: I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this Policy with and without inflation protection, and

   ☐ I ACCEPT inflation protection. ☐ I REJECT inflation protection.

4. SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER: I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

   ☐ I ACCEPT ☐ I REJECT the Shortened Benefit Period Non-forfeiture Rider.

5. DECLARATION AND APPLICATION CONDITIONS

   To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use this application or require, at their expense, that I see a health care professional to determine if my application is accepted. I understand that the premium for the coverage I have applied for is based on medical underwriting. The premium I was quoted includes certain assumptions regarding my health. The premium for my policy may be different from the premium I was quoted. My coverage will begin when I am notified of the effective date of coverage, or if selected, my alternate effective date. To receive benefits under this policy, I understand I must satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

   I authorize my Employer to verify my employment status for MedAmerica Insurance Company (the Company) by phone or by census. If I am self-employed, I understand that a representative of the Company will contact me to confirm my Actively at Work status.

   I acknowledge receipt of the Outline of Coverage, Suitability Personal Worksheet (if applicable in my state), Rate and Disclosure Form (if applicable in my state), and appropriate Shopper's Guide.

   I understand the Producer or Broker of Record for my Policy, and any managing entities (which may include an affiliate of the Company), may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

I understand that with this signature I am agreeing with all applicable conditions contained in this Signatures and Authorizations.

Dated at: _____

City State Month Day Year

APPLICANT'S SIGNATURE: _____

VI. PRODUCER STATEMENT

1. Has the Applicant purchased any other health insurance policy from you during the past five (5) years? *If Yes, provide the following information:*

COMPANY	TYPE OF POLICY	POLICY NUMBER	IN FORCE:
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO

2. By my signature on this form I certify that:
   (a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
   (b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
   (c) I am in compliance with the Long Term Care Insurance requirements in the state of residence of the Applicant as shown on his/her/their Application.
   (d) I have delivered the Outline of Coverage, Suitability Personal Worksheet (where required), and Rate Disclosure Form (where required), and appropriate Shopper's Guide to the Applicant at the first time of solicitation.

_____ _____
Soliciting Producer Name (*Please print)* Writing Number

_____
Agency Name

Phone Number (Best number to reach soliciting producer) : (_____) - _____

SOLICITING PRODUCER SIGNATURE: _____ DATE: _____

3. Are you SPLITTING the Commission Payment? ☐ YES ☐ NO

If YES, List all producers receiving compensation, their Writing Number(s), and % splits. The first producer listed MUST be the soliciting producer and the producer of record. Case splits must total 100%. (*Only Licensed and Appointed Producers/Brokers may receive compensation.)*

Soliciting Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing# _____ : _____ %
Please Print First Name, Last Name TOTAL: 100 %

4. Amount of Conditional Premium Check (attached): **$** _____
If Conditional Premium is collected, Modal Premium is Required*

*If EFT, 2 months premium is required if Payroll Deduction or [Employer][Association] Paid, no premium is required.

Special Requests, Remarks, and Instructions:

MEDAmerica INSURANCE COMPANY
An Excellus Company — Home Office: Pittsburgh, PA

Simplicity[ii]
Long Term Care Insurance
TAX QUALIFIED COVERAGE

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

[SIMPLIFIED][MODIFIED]
SPL2-336-AR-0708

HEALTH QUESTIONS: Please read the Instructions Carefully.

_____ ___-__-____
Applicant Name *Applicant Social Security Number*

INSTRUCTIONS: You must answer each question by checking YES or NO.

1. Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions: ☐ YES ☐ NO

- Diabetes Treated with Insulin
- Any Diabetes with Skin Ulcers
- Multiple Joint Replacements OR Any Joint Deformities
- Kidney Disease
- Liver Cirrhosis
- Hepatitis B, C, D, or E
- Stroke or Transient Ischemic Attack (TIA)
- Memory Loss, Alzheimer's Disease, or Dementia
- Bipolar Disorder, Schizophrenia, Psychosis, Mental Retardation
- Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis
- Multiple Sclerosis
- Parkinson's Disease/Parkinsonism
- Muscular or Neurological Conditions causing Limits
- Post-Polio Syndrome
- Lupus (SLE)
- Scleroderma
- Amputation-Due to Disease
- Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant
- Metastatic Cancer, Multiple Myeloma
- Pulmonary Embolism
- Carotid Artery Disease
- Peripheral Vascular Disease
- AIDS- You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS.

2. *In the PAST YEAR*: Have you needed assistance or supervision in taking medication, performing activities of daily living* OR used any Medical Equipment**? ☐ YES ☐ NO

*Activities of Daily Living Include Bathing, Dressing, Eating, Toileting, Getting In and Out of Bed, Bowel OR Bladder Control
**Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stair lift, or Home Intravenous Medications.

3. *In the PAST YEAR*: Have you been admitted to a nursing home, assisted living facility, psychiatric hospital, OR alcohol/drug rehabilitation? ☐ YES ☐ NO

STOP! If questions 1,2 OR 3 are checked "Yes," we cannot offer coverage at this time. Do not Submit the Application.

4. *In the PAST YEAR*: Have you been hospitalized overnight (except for uncomplicated childbirth) OR been advised to have surgery, OR been diagnosed with cancer AND received OR been advised to receive Radiation or Intravenous Chemotherapy? ☐ YES ☐ NO

5. *In the PAST YEAR*: Have you been referred to or received medical advice, consultation or treatment from any physician specializing in any of the following: Neurology (Nerves), Nephrology (Kidney/Renal), Pulmonary (Respiratory), OR Hematology (Blood)? ☐ YES ☐ NO

6. *In the PAST YEAR*: Have you been declined, postponed, or had your benefits modified for a long term care application? ☐ YES ☐ NO

[Filing_Note: = Simplified]

[IF ALL QUESTIONS 1-6 ARE NO - SIGN BELOW AND CONTINUE TO HIPAA MEDICAL AUTHORIZATION.

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

To the best of my knowledge and belief, I have answered all questions completely and truthfully.

Dated at: _____ _____ _____ _____ _____
City State Month Day Year

☛ APPLICANT'SIGNATURE:] _____

[Filing_note = Simplified]
[IF QUESTIONS 4, 5, OR 6 are "Yes," CONTINUE TO ADDITIONAL HEALTH QUESTIONS]

[Filing_note= Modified, will continue to Additional Health Questions]

[ADDITIONAL HEALTH QUESTIONS:]

List ALL Current Medications - Use Extra Paper if Needed. ☐ No Medications

Medication	Dosage (x/day)	Reason Taking	#Months On Med

PHYSICIANS: List ALL Physicians seen in the last 5 Years.

Physician(s) Name	Physician(s) Street Address, City, State, Zip	Phone #	Date Last Seen
1. Primary Care Physician			
2. Other Physicians (Indicate Specialty)]			

[ADDITIONAL HEALTH QUESTIONS CONTINUED:

During the past 5 Years have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services from a medical professional for, or taken any medication for any condition(s) or symptom(s) of the following (1-8)?

1. Any Heart, Circulatory, Vascular, or Blood problems? ☐YES ☐ NO
   Examples (List not all inclusive): Aneurysms, Strokes, TIA, Heart Attack, Angina, Dizziness, Pacemaker, Chest Pain, Irregular Heartbeat, Vascular Headaches, Peripheral Vascular Disease, Carotid Disease, Thrombocytopenia, Anemia and Hypertension
2. Any Bone, Joint, Muscular or Connective Tissue problems? ☐YES ☐ NO
   Examples (List not all inclusive): Arthritis, Osteoporosis, Osteopenia, Back Problems, Paget's Disease, Polymyalgia, Rotator Cuff Tear, Bunion Surgery, Spinal Stenosis, Connective Tissue Disease
3. Any Respiratory Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema, Bronchitis, Sarcoidosis
4. Any Endocrine Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Diabetes, Thyroid problem, Hormone Replacement, Pancreatitis, Hyperparathyroidism
5. Any Neurological, Eye or Ear Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Bell's Palsy, Blindness, Carpal Tunnel, Cerebral Palsy, Epilepsy, Parkinson's Restless Leg, Seizure Disorder, Tremors, Unsteadiness, Loss of Balance, Falls, Glaucoma, Macular Degeneration
6. Any Mental, Alcohol or Drug Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Anxiety, Depression, Alcoholism, Manic Depression, Memory Loss
7. Any Digestive, Bladder, or Kidney Problems? ☐YES ☐ NO
   Examples (List not all inclusive): Colitis, Colon Polyps, Gallbladder Disease, GI Bleed, Hiatal Hernia, Loss of Appetite, Nephrectomy, Renal Disease, Prostate Enlargement, Stress Incontinence, Weight Gain, Weight Loss, Dyspepsia
8. Any Cancer? ☐YES ☐ NO
   Examples (List not all inclusive): Breast Cancer, Prostate Cancer, Uterine Cancer, Thyroid Cancer, Leukemia, Skin Cancer
9. In the *past 2* years have you used tobacco products? ☐YES ☐ NO

   If "YES," Type: _____Amount/Frequency: _____/_____ *If quit, give date:* _____

10. What is your Height_____ and Weight_____?

Provide Details of Diagnoses including Date of Onset, Tests/Treatments/Follow-up over the last 5 Years for All Conditions.
Please use extra sheet of paper if needed.

Description of Condition/Problem	Date of Onset MM/YYYY	Type of Tests/Treatment/Follow-Up/Medication Changes in last 5 years	# Months Stable (No Change in Treatment)]

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.
CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

To the best of my knowledge and belief, I have answered all questions completely and truthfully.

Dated at: _____ _____ _____ _____ _____
City State Month Day Year

☛ APPLICANT'S SIGNATURE: _____

HIPAA MEDICAL AUTHORIZATION (Uses and Disclosures of Medical Information)
Must be signed by ALL Applicants.

This is a HIPAA compliant authorization. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of medical information about me.

From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic or other health care provider or health related facility, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments, to furnish MedAmerica Insurance Company and/or designated business associates acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the [LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com]. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

PRINT APPLICANT NAME: _____

APPLICANT DATE OF BIRTH: _____

APPLICANT SOCIAL SECURITY NUMBER: _____

☛ APPLICANT'S SIGNATURE: _____ DATE: _____

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MEAM-126128663*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*42219*
Company Tracking Number:	*S2-345R-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.004 Partnership*
Product Name:	*S2-345R-AR*		
Project Name/Number:	*S2-345R-AR/S2-345R-AR*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification 04/24/2009

Comments:

Attachment:

Readability Certification AR.pdf

Review Status:

Bypassed -Name: Application 04/24/2009

Bypass Reason: Applications are under the Forms Schedule tab for review and approval.

Comments:

Review Status:

Satisfied -Name: Health - Actuarial Justification 04/24/2009

Comments:

Addendum to previously approved Memorandum. Rates have not changed.

Attachment:

AR ep addendum.pdf

Review Status:

Bypassed -Name: Outline of Coverage 04/24/2009

Bypass Reason: Outline was previously approved and has not changed.

Comments:

Review Status:

Satisfied -Name: Cover Letter 04/27/2009

Comments:

Attachment:

Cover letter AR.pdf

MEDAmerica
INSURANCE COMPANY
An Excelsus Company Home Office: Pittsburgh, PA

Administrative Offices:
165 Court Street
Rochester, NY 14647
1-800-544-0327

CERTIFICATION

This is to certify that the forms listed below exceed the Flesch Reading Ease test score minimum of **40** in compliance with **Arkansas** insurance policy readability law:

Form Name	Form Number
Application – Individual	S2-345R-AR
Application – EP / Association A	S2-346A-AR
Application – EP / Association B	S2-346B-AR

These forms were scored together with the Policy associated forms.

Certification by:

Christopher D. Perna

President
Title

MedAmerica Insurance Company
Addendum To Actuarial Memorandum

Long Term Care Policy Forms-Product Series Simplicity[ii] SM
Tax Qualified Policy Series SPL2-336-AR-0708

PRODUCT OR RIDER	FORM NUMBER
Long Term Care Policy	SPL2-336-AR-0708
Compound – 2 X Maximum Rider	S2-CMP2X-AR
Compound – No Maximum Rider	S2-CMP-AR
Simple Benefit Increase Rider	S2-SBIR-AR
Restoration of Benefits Rider	S2-ROBR-AR
Return of Premium Rider	S2-ROPR-AR
Full Return of Premium Rider	S2-FROPR-AR
Shortened Benefit Period Rider	S2-SBPR-AR
Shared Care Rider	S2-SCR-AR
Survivor Rider	S2-SVR-AR
Shared Waiver Rider	S2-SWR-AR
Community Only Rider	S2-COMMR-AR
Facility Only Rider	S2-FACR-AR

Policy Series SPL2-336-AR-0708

Section V - Discounts of the original memorandum is hereby replaced with the following:

DISCOUNTS

Employer Sponsored: Employer sponsored groups are eligible for a 5% discount and reduced underwriting. The discount is funded by lower underwriting, issue, and marketing costs. In addition, all insureds in this category receive standard (Rate Group II) premium rates. Married rates are a 30/70 blend of the married, one insured and the married both insured premium rates.

Association: Member based Endorsed Association plans are eligible for a 5% discount and reduced underwriting. The discount is funded by lower underwriting and issue costs. All insureds in this category receive standard (Rate Group II) premium rates. The standard married classifications apply.

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

Administrative Office:
165 Court Street
Rochester, NY 14647

Product Filing/Contracts Management
Tel: (800) 544-0327 x 6550
Fax: (585) 238-3675
E-Mail Address: lisa.culhane@medamericaltc.com

April 27, 2009

Jay Bradford, Commissioner
Arkansas Department of Insurance
1200 West 3rd. Street
Little Rock, Arkansas 72201-1904

RE: **MedAmerica Insurance Company** **NAIC #:** 69515 00
Form and Rate Filing –Tax Qualified Long-Term Care Insurance **FEIN #:** 34-0977231
FORM #: S2-345R-AR; S2-346A-AR; S2-346B-AR

Dear Commissioner Bradford:

The enclosed form filing is submitted for your review and approval. This Long Term Care Insurance Product is intended to be tax-qualified under section 7702B(b) of the Internal Revenue Code. Revisions have been made to our applications deleting our Affiliation program and replacing it with Association. Also simplify our application process by creating a Simplified and Modified application. The Policy and forms were originally approved under SPL2-336-AR-0708 on 8/13/2008.

S2-345R-AR (formerly S2-345-AR-0708) has been revised deleting Affiliation from the application.

S2-346A-AR and S2-346B-AR are replacing S2-346-AR-0708. S2-346A will be used to collect the applicants identifying information and benefit choices. S2-346B is now the Health Questionnaire.

An Addendum to the Actuarial Memorandum is included under the Supporting documents tab. This addresses the change from Affiliation to Association. No changes have been made to rates.

No other forms have been modified from their original submission. The application format may change depending on the medium used for implementation; however the content will remain the same.

Thank you for your consideration of this filing. Please do not hesitate to contact me at the number listed above if I can be of any assistance as you complete your review.

Sincerely,

Lisa Culhane
Compliance Analyst